FEELING BLUE?
THE IMPORTANCE OF A CONFIDANT FOR THE WELLBEING OF OLDER RURAL MARRIED AUSTRALIAN AND AMERICAN MEN

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ABSTRACT

Older men have been described as relatively invisible in gerontological research, with knowledge about the wellbeing of older men in a rural and cross-cultural context limited. Thus, this research investigated the prevalence and predictors of mild depression, or "the blues", among older married Australian and American men living in rural areas. Comparable data from two separate studies, phone interviews for Americans (n=118) and a self-complete postal questionnaire for Australians (n=53), was integrated to determine whether the prevalence and predictors of mild depression, specifically demographic factors, health, pain, functional limitations and social networks, differed according to nationality. Approximately 20% of older rural men described themselves as recently "feeling blue" or "down in the dumps". Logistic regression analyses demonstrated that, for both older Australian and American men, mild depression was predicted by functional limitations and not having someone to trust and confide in. These findings emphasise the importance of friendships beyond the marital relationship for older married rural men. Unfortunately, the remoteness and isolation of rural life, combined with the "masculine culture of the bush" and men's resistance to share their feelings, may impede the formation of close friendships. As the first study to identify the predictors of mild depression for older married men in a

rural cross-cultural context, this research highlights the importance of friendships for male wellbeing in rural Australia and America.

KEY WORDS: mild depression; older men; rural ageing; cross-cultural context.

Characterised by chronic sadness, depression is estimated to be the second greatest contributor to the global burden of disease by 2020 and is the most common mental health problem (World Health Organisation, 2001). The emotional, social and financial impacts of depression on individuals, families, communities and countries ensures that understanding and minimising depression is an international public policy priority (Murray & Lopez, 1996). At a personal level, depression negatively impacts on quality of life and family relationships, whilst at a societal level, depression is linked with loss of productivity and increased national health expenditure (Hawthorne, Cheok, Goldney, & Fisher, 2003; Hickie, 2004). Tragically, it is estimated that 60% of suicides are a direct result of depression, which too often goes unrecognised and untreated (Hawthorne et al., 2003).

Among older adults, being depressed is a relatively common experience. An estimated 1 in 3 older people will experience minor depression, with approximately 5% diagnosed with clinical depression (Paivarinta, Verkkoniemi, Niinisto, Kivela, & Sulkava, 1999). Given that researchers believe "depression remains underrecognized and undertreated in older persons" (p25, Morley, 2004), it is likely that the number of older people experiencing depression is even higher. In the context of an ageing population, with the proportion of Australians and Americans aged 65 years or over predicted to double in the next twenty years (Australian Institute of Health and Welfare, 2004), the obvious impact of global population ageing is that there will be an increase in the number of older people experiencing depression. Thus, enhancing our understanding of the prevalence and predictors of late-life depression, and the development of appropriate interventions and support mechanisms, is a global priority.

To date, however, although researchers have identified the precursors and predictors of late-life depression, such as illnesses, negative life events and psychological stressors (see Reynolds & Kupfer, 1999), only a handful of studies have focussed on how older men acknowledge depressive symptoms and manage depression. Dominant socio-cultural norms, portraying the ideal man as strong, stoic and self-sufficient, ensures that, regardless of their age, men are generally reluctant to acknowledge, discuss or seek help for mental health issues, particularly depression (Foskey & Avery, 2003; Hegney et al., 2003; Hodgetts, & Chamberlain, 2002). Even in today's therapeutic society, acknowledging that they feel depressed and seeking help is still difficult for men, as it is "culturally more acceptable for women to express their emotional difficulties" (p494, Tijhuis, de Jong-Gierveld, Feskens & Kromhout, 1999). Thanks to societal norms and the stigma still surrounding depression, men are less likely than women to report depressive symptoms, acknowledge mental health issues or seek help for emotional problems (Nazroo, Edwards, & Brown, 1998), with some researchers provocatively suggesting that "being a woman may, in fact, be the strongest predictor of health-promoting behavior" (p4, Courtenay, 2000). For older men, particularly vulnerable to depression as they navigate the transition from work to

retirement and come to terms with the loss of a work identity (Alpass & Neville, 2003), being depressed can be extremely isolating:

> **…**many elderly patients may deny psychological symptoms of depression or reject the diagnosis because of the stigma attached to it. The effects of stigma on acceptance of the diagnosis seem particularly significant among men, who also have the highest rates of completed suicide in later life" (p1170, Reynolds & Kupfer, 1999).

For older men living in traditional rural environments, the internal and external barriers to acknowledging and over-coming depression are particularly daunting. First, at a structural or external level, mental health risk factors are amplified in rural environments, where residents do not have easy access to external resources, infrastructure or formal social support systems, often living hours from their nearest neighbour or town (Curtin, 2001). For example, access to mental health services is more difficult in rural Australia, with fewer psychiatrists located in rural locations (3.3 per 100 000 people) than metropolitan populations (14.2 per 100 000 people, Australian Institute of Health and Welfare, 2002). Second, at an internal or individual level, rural residents are also typically highly independent, self-reliant and private, thus making them reluctant to seek help (de la Rue & Coulson, 2003). For older rural men, the experience of depression is particularly difficult, as they are taught from childhood to suppress their feelings and exposed to societal messages promoting a view of hegemonic masculinity, where man on the land is portrayed as indomitable, self-reliant and all-conquering (Fluck, 1987; (Outram, 2003). Unfortunately;

> Men who subscribe to more traditional gender roles may view their problems as signs of weakness, as feminine, and as less common among men. Men who place elevated emphasis on adhering to gender roles may believe that admitting to certain problems would be judged, looked down on, and stigmatized…more traditional men may perceive certain problems that are not appropriate to the masculine role (such as depression) as stigmatizing ("others will see me as weak;" Warren, 1983) (p128, Magovcevic & Addis, 2005).

The combination of these external (e.g., isolated physical environment, limited access to support services) and internal (e.g., private, independent) characteristics typical of the rural environment (Outram, 2003) ensures that older rural men may view feeling depressed as a sign of weakness and find it difficult to seek help. In addition, the diversity of rural communities, economically reliant on different industries such as farming, tourism, forestry or mining, ensures that each rural community is unique in terms of size, population compositions and societal norms.

Surprisingly, depression among older rural men remains relatively uncharted territory ((Michalak et al., 2002; Patrick, Cottrell, & Barnes, 2001; Wang, 2004). Researchers, focused on the experiences of older women who out-number men in late-life, know little about the wellbeing of older men who have been described as "relatively invisible" in gerontological research (Arber, 2004; Fleming, 1999; Thompson, 1994). Our knowledge about older men in a rural and cross-cultural context is especially limited, with researchers typically focussed on understanding the lives and lifestyles of their more visible urban-dwelling peers (Patrick, Cottrell & Barnes, 2001).Research focussed specifically on depression in older rural men is rare, with limited research emphasising how difficult it is for rural men to acknowledge mental health issues and seek help.

For example, in Ireland, Barry et al (2000) found that rural Irish men were more likely to conceal mental health problems than women and felt unable to talk about their problems. In Australia, to our knowledge, there has been no published quantitative research (and only two qualitative studies) focussing specifically on the predictors, prevalence and experience of depression reported by older rural men. The qualitative studies illustrate the difficulties older rural Australian men have acknowledging depression, with one participant commenting "*I was just in a deep depression and*

didn't realise" (p11, Hegney et al., 2003). Similarly, as part of a pilot peer support programme for farmers approaching retirement age, Foskey and Avery (2003) found that their participants "told stories of depression, ill-health, isolation and death soon after following retirement from farming", with one participant commenting, "*I saw my father get elderly after he left the farm. He didn't have any friends and just sat in the house there*" (p7, Foskey & Avery, 2003). Unfortunately, in rural Australia, the:

> continuing, ill informed attitudes in rural communities regarding mental health problems is one of the greatest barriers for rural men to seek out help during difficult times or even feel they can discuss the matter with family or friends. The culture of self-reliance and the so called 'stiff upper lip' leaves little room for error or weakness (Fuller et al., 2000), thus adding to the pressures already experienced by men during difficult times (p 20, Hegney et al., 2003).

This research, by identifying the predictors of mild depressive symptoms in older men living in rural Australia and America, aims to full a crucial research gap. Cross-sectional and longitudinal studies have repeatedly identified the key factors that typically predict depressive symptoms, specifically differences in health (i.e., illnesses, disability, pain, instrumental activities of daily living), social support and interactions (i.e., friends and family, confidants), and key demographic characteristics (i.e., sex, age, income, marital status). The extent to which each of these universal predictors of depression predicts symptoms of mild depression or "the blues" among older rural men in Australia and America, however, is unclear. With rural life in both counties characterised by limited resources, infrastructure and formal social support systems, and rural residents often living hours from their nearest neighbour or town, there is little doubt that life in rural and remote locations may be particularly challenging for older people, who often experience increased frailty and illness (Outram, 2003). Given the commonality of culture and environment, one might predict that despite the 12,000 kilometres physically separating them, older rural men in Australia and America might experience the same physical and emotional responses to the ageing process. On the other hand, subtle variations and differences in socio-cultural values, norms and behaviours may mean that the prevalence and predictors of depressive symptoms might differ. Understanding how cultural differences, such as differences in nationality, ethnicity or living in an urban or rural environment, impact on depression is increasingly important as researchers attempt to identify universal aging processes and whether the experience of rural aging is universal across cultures and nationalities (Jackson, 2002).

Moreover, in light of recent research linking chronic mild depression in older people with increased risk for infections and cancer (McGuire, Kiecolt-Glaser & Glaser, 2002), the early detection and treatment of depression symptomatology is important from both physical and mental health/quality of life perspectives. This research, focusing on investigating prevalence and predictors of mild depression or "the blues" among older married rural men living in America and Australia, is an important first step towards enhancing our knowledge about the experiences of older rural men, who by virtue of societal expectations of hegemonic masculinity, their age and their residential location, are particularly vulnerable to depression symptoms.

Method

This cross-sectional research amalgamates two separate studies, phone interviews for Americans (n=53) and a self-completed postal questionnaire for Australians (n=118), focusing on the predictors of mild depressive symptoms (i.e., the blues) for older married rural men aged 65 years and over. The two different samples, and the comparable measures, are described below.

Rural Australian Men

Participants in the Australian Active Ageing Survey (Triple A) were members of National Seniors, an Australian-wide senior's organisation, who were asked to complete a survey about active ageing in Australia. The 177-item survey, including questions about work, learning, health, home environment, life events, wellbeing and basic demographics, was posted to 6,000 members across Australia in 2004. To encourage participation, participants were offered the opportunity to enter a prize draw for twenty $100 supermarket gift vouchers. There was a 44% (*n*=2,645) response rate. This paper focuses specifically on the responses of rural married men over the age of 65 years (*n*=118).

Rural American Men

Using an existing database owned by the Center for Gerontology at Virginia Polytechnic Institute and State University (Virginia Tech), households with members aged 65 or older living in the rural southwest region of Virginia were randomly selected to participate to participate in a telephone interview about their health and psychological well-being in 2000. Of the 4,050 qualifying records, staff from the Virginia Tech Center for Survey Research (CSR) completed telephone interviews with 2,034 older adults or 50% of the eligible sample (Blieszner, Roberto, & Singh, 2001-2002).The focus of this paper is on the married men (*n*= 53).

Measures

Demographic Variables

In both studies, participants reported their sex, age and marital status, with this paper focussing on married males aged 65 years or older.

Health

Subjective overall health was measured with a Likert scale anchored at "excellent" and "poor" in both studies, although the Australian study utilised a 5-point Likert scale and the American study a 4-point Likert scale. To ensure comparable data, the Australian responses were recoded onto the 4 point scale by combining the excellent and very good responses.

Functional Health

To make responses comparable, participants' responses to questions about their functional health, specifically activities of daily living (ADL), instrumental activities of daily living (IADL) and mobility was calculated as a score ranging from one to six limitations. Seven dichotomous questions in the American study and six items in the Australian study assessed participant's functional health limitations. To ensure comparability, Australian responses to the SF-36 items were recoded into a dichotomous limited or not limited by combining limited "a lot" and "a little". Three items assessed IADL in both studies. Both studies asked participants whether they were currently driving a car, with participants also indicating the extent health limits moderate activities (AU) or ability to do heavy housework (US); and whether their health limits lifting or carrying groceries (AU) or ability to shop for groceries in last month (US). As ADL was assessed by one item in the Australian study, the extent health limited bathing or dressing self (AU) and two items in the American study, the two American items (ability to bath and dress self) were combined so that inability to do either was characterised as limited. Two items assessed mobility in both studies, specifically participants ability to walk several hundred yards (AU) or one block in the last month (US), and whether their health limited climbing one flight of stairs (AU) or whether they

could walk up and down stairs in the last month (US). Items were recoded to ensure comparability and then were summed, such that higher scores indicated a greater number of functional health limitations.

Pain

Participants in the American study were asked whether they had experienced pain that lasted one month or more over the past year (yes/no response), and if yes, whether they would rate their pain as mild, moderate or severe. Participants in the Australian study indicated on a 6-point Likert scale item how much bodily pain they had experienced in the past four weeks, ranging from none to very severe. To make responses comparable, the Australians responses were recoded into two variables, a dichotomous presence of pain and a 3-item mild, moderate or severe pain rating.

Frequency of Contact with Family and Friends

Using a 6-point Likert scale anchored at daily and less than once a month, three items measured the frequency with which American participants had contact with their children, grandchildren and friends. In the Australian study, participants indicated on two 8-item Likert scale items from Duke's Social Index (Koenig et al., 1993), anchored at none and seven or more times, how many times participants spent time with someone who did not live with them in the last week and the frequency of telephone contact with friends and relatives in the past week. The highest scoring item was selected and recoded into a 4-point indicator of overall contact frequency, anchored at 0 and 3. Specifically zero represents no or limited contact, defined as one or less interaction in the last week (AU) or less than once month (US); one is defined as 2-3 interactions in the last week (AU) or monthly (US); two is defined as 4-6 interactions in the last week (AU) or weekly (US); and, finally, three is defined as 7+ interactions in the last week (AU) or daily (US).

Presence of Confidant

In the American study, one dichotomous question assessed whether Americans had someone to trust and confide in. Australian respondents originally indicated how often they could talk about their deepest problems with at least some of their family and friends on a 5-point Likert scale (Koenig et al., 1993). To achieve comparability with the American responses, AU responses were recoded dichotomously with none of the time and hardly ever characterised as not having someone to confide in and some, most or all of the time characterised as having someone to confide in.

Mild Depressive Symptoms

In both studies, one question assessed mild depressive symptoms. American participants responded to the dichotomous question, "during the past week, did you feel that you couldn't shake off the blues even with help from your family or friends", whilst Australian participants indicated on a five-point Likert scale (anchored at all of time and none of the time) whether "during the past 4 weeks, have you felt so down in the dumps that nothing could cheer you up". To make responses comparable, the Australians responses were recoded dichotomously with none of the time recoded as no and a little, some, most and all of the time coded as yes.

Results

For older married men in rural Australia and America, with an average age of 74 years, the prevalence of mild depression did not significantly differ as a function of nationality: 17% of American men reported that they recently felt blue, compared to 31% of Australian men.

Using SPSS 10.0, a logistic regression analysis was conducted to determine what factors, specifically health (self-rated health, functional limitations, pain rating), social support (contact with family and friends, presence of confidant) and nationality (Australian or American), best predicted mild depression in older rural men. As Table 1 illustrates, mild depression [χ^2 (6, *N*=171)=30.75, *p*=.000] was predicted by functional limitations, such that increased functional limitations was associated with increased mild depressive symptoms [*b*=.356, Waldχ^2 =6.27,*p*=0.012], and not having someone to trust and confide in [*b*=1.47, Waldχ^2 =4.15,*p*=0.000].

Table 1: Logistic regression analysis with "the Blues" as dependent measure

	B	Wald	Significance
Health			
Self-Rated Health	.017	.003	.956
Functional Limitations	**.356****	6.267	.012
Pain Rating	-.421	2.598	.107
Social Support			
Contact with family and friends	-.618	1.547	.214
Confidant	**1.466***	4.148	.042
Nationality	-.547	.950	.330

Discussion

This research, demonstrating that approximately 20% of older men living in rural Australia and America report feeling "blue" or "down in the dumps", enhances our knowledge about a significant area of concern in the context of a rapidly ageing population. On the one hand, the fact that mild depression was predicted by functional limitations and not having someone "to trust and confide in" emphasises the importance of mobility, independence and social support in older rural men's wellbeing. On the other hand, given estimates that one in three older people will experience minor depression (Paivarinta et al., 1999), the finding of a lower prevalence rate of one in five for older rural men raises the possibility that rurality, and the strong sense of community, traditionally associated with rural communities (Hegney et al., 2003; McKenzie, & Frencken, 2001) may act as a protective factor for some older men. Together, these findings provide compelling evidence for researchers to further investigate the impact of rurality on the wellbeing of older men and women.

Rural communities are frequently described as having a strong sense of community, social connectedness and social capital, as "despite the physical isolation of some people living in rural areas, a strong bond exists between the individuals and the community" (p19, Hegney et al., 2003). It is important to note that this perception of the idyllic rural lifestyle masks the challenges facing some rural communities, where the decline of rural industries and economic disadvantage contributes to domestic violence, loneliness, depression and suicides. These issues further highlight the importance of community interactions for wellbeing. Unfortunately, by necessity, remaining actively involved in rural communities requires a certain level of health and mobility in order to

participate in activities or visit friends and neighbours who live long distances away. For some older adults in rural areas, the progressive decline of health and mobility associated with ageing may have a negative impact on their wellbeing by restricting their ability to remain involved in community life. Thus, the finding that functional limitations predicted mild depressive symptoms for older rural men in Australia and America is perhaps not surprising, given the physically-intense nature of rural life and the changes in lifestyle they may experience as a consequence of ageing. These findings reinforce the importance of older men establishing a new identity upon retirement, one not as reliant on the intense physical activity typical of rural life, and seeking alternative ways to remain engaged and active in community life when their mobility declines. From a policy and service delivery perspective, it is clear that innovative responses are needed to ensure that older rural men remain actively engaged and feel connected to their community.

The isolated nature of rural communities, where residents may see friends infrequently thanks to the great distance involved, also suggests that the quality of the marital relationship is extremely important. Unfortunately this research, focussing on the experiences of older rural married men, found that the absence of a confidant predicted mild depression symptoms. The obvious implication, therefore, is that some older rural men felt that they could not confide in their wives. This finding is intriguing for several reasons. First, we focussed on the experiences of married men, who theoretically have a spouse to trust and confide in. Indeed, as it is well-documented that women typically report larger and stronger social support networks and support (Antonucci & Akiyama, 1987), researchers frequently describe marriage as protective factor for men, in the sense that their partner is the primary (and often only) source of support (Davidson, 2000). Clearly, the importance of a good marital relationship to men's wellbeing cannot be over-estimated, particularly for older rural men who may rely heavily on their spouse for social support as they live a great distance from family, friends and the infrastructure for social activities, such as restaurants, recreational facilities and meeting places.

Unfortunately, to date, although marital happiness is repeatedly linked with psychological well-being and conflict is linked with depression (Bookwala & Jacobs, 2004), the importance of *older* men's relationship and interactions with their wife remains understudied (Sandberg, Miller, & Harper, 2002). The limited research investigating depression in mature marriages suggests that "wives' depression is more closely related to relationship functioning than that of husbands" (p400, Sandberg & Harper, 1999); potentially, however, in rural areas the same may be true for older men. That is, in rural areas typified by geographic isolation and a culture that values independence and privacy, developing strong social support networks and a confidant outside of the marital relationship may be particularly difficult for older men. Thus, this may mean that older rural men may rely almost exclusively on their wives for support. When that support, for whatever reason, is not there, older men may feel they have no where else to turn for help.

As we did not directly ask participants about the quality of their marriage or support they received from their wives, our conclusions must be limited. However, future research should focus on the impact that marital relationship and functioning has on depression in older rural men. Intriguingly, limited research investigating depression among rural men in Australia also highlights the importance of marital support. In a qualitative study, Hegney et al. (2003) found that participants commented on the importance of social support from family and friends, practically their spouse. One rural man commented:

> I guess that meant my wife and I drifted, when you don't have that sort of mutual support happening and you're each doing your own thing. I felt relatively isolated. I've never really felt that there was support, I think my wife just

> expected me to be able to cope with stress on my own, I guess because she could with the things that affected her (p16, Hegney et al., 2003).

Clearly, future research, with larger sample sizes and longitudinal designs, is needed to explicitly examine the experiences and wellbeing of older rural men. To date, although there has been a call for "an increased male awareness of the importance of socialization and relationship issues" (Pinquart, 2003), there remains a masculine cultural ideal emphasising self reliance that makes it difficult for men to share their problems with others (Tower & Kasl, 1996). The stigma still associated with depression in rural communities (Hegney et al., 2003) combined with older men's reluctance to discuss their feelings (Magovcevic & Addis, 2005) may also explain why mild depressive symptoms is predicted by lack of a confidant. The obvious problem, however, is that like any other medical illness, if men do not seek treatment, their depression will worsen. Unfortunately, the immense internal and external barriers to help-seeking for mental problems in rural communities, combined with older men's innate reluctance to discuss their feelings, makes it all too likely that many older men will continue to suffer in silence.

The finding that rates of mild depressive symptoms are similar in both the Australian and American context emphasises the importance of rurality as a dimension that impacts on successful ageing. It is both provocative and informative to think that older rural men in Australia and America may be more similar to each other than their urban peers living in the same country. Of course, regardless of geographic location, rural culture, typified by physical and social isolation, differs markedly from urban living. This research suggests that the particulars of rural living can foster a unique set of conditions that can contribute to or detract from successful ageing and the wellbeing of older men. Specifically, this research suggests that rurality, by increasing isolation, is a risk factor for mild depressive symptoms in older Australian and American men. Thus, policy-makers and service-providers in rural areas need to be aware of how declining mobility may restrict the social connectedness and interactions of older rural men. The development of interventions and programmes that are accessible from home, such as innovative communication strategies such as home-visits, phone link-ups and online support, are strategies that will help met the unique needs of older rural men and potentially reduce the prevalence of depression.

Our conclusions can only be tentative, given the limitations of this research. The most obvious limitation is that this article reports on the comparable findings of two independently conducted studies, with the cross-sectional design further limiting our ability to make causal statements. In an ideal world, the studies would have been designed identically or to be complimentary; however, we have attempted to err on the side of caution when matching the different variables, recoding the different measures as conservatively as possible and precisely detailing each comparison. Indeed, the definition of mild depression in this article is relatively broad, a dichotomous measure of whether older rural men reported feeling blue in the last week (America) or so down in the dumps in the last month that nothing could cheer you up (Australia). Whilst clearly not a diagnosis of clinical depression, the finding that one in five older rural Australian and American men "felt blue" recently is concerning. Indeed, the discovery that the rate and predictors of mild depressive symptoms reported by older rural men was similar in two countries separated by more than 12,000 kilometres strengthens the validity of this research, emphasising the need for researchers to focus on the experiences and wellbeing of older rural men in a cross-cultural context.

Whilst the emergence of a therapeutic society in recent years means that younger adults are more likely to view depression as a treatable illness and seek counselling or medication to help overcome this mental health challenge, it seems that older adults, particularly those living in traditional rural communities, are often reluctance to acknowledge or seek help for depression. We view this research as a vital step in

enhancing our knowledge about the risk and protective factors associated with depression symptoms in older married rural men. The concerning finding that one in five older rural Australian and American men report recently feeling “blue” or “down in the dumps” highlights the necessity of developing appropriate interventions that will resonate with the ageing rural male. We hope that this research, emphasising the value of confidents, might serve as a catalyst to both researchers and policy-makers, prompting further investigation into the experience of depression and potential interventions for older men in rural Australia and America.

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